STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 01 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTER	281 S CO RD 200 E CONNERSVILLE, IN47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/19/11 Facility Number: 000225 Provider Number: 155332 AIM Number: 100267670 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Heritage House Rehabilitation & Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered excluding the twenty foot pantry corridor in the kitchen. The facility has a fire alarm system with	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 100 and had a census of 86 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/22/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 8 sets of fire doors were arranged to latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects any resident using the Therapy Hall and Service Hall. Findings include:	K0044	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statment of deficiencies, or of any violation of regulation.The provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post certification review on or after 8/18/2011.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The (2) sets of fire doors in question were rubbing on paint build up and has been adjusted for speed to ensure proper closure. If painting occurs in the hallways where firedoors exist, doors will immediately be checked to ensure proper latching.How will you identify	08/18/2011

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	Based on observations on 07/19/11 during a tour of the facility from 10:00 a.m. to 1:00 p.m. with the maintenance supervisor, the Therapy Hall and Service Hall sets of fire doors each failed to latch into the door frames on two separate attempts. Based on an interview with the maintenance supervisor on 07/19/11 at 11:00 a.m., the facility was originally constructed with eight, two hour fire barriers equipped with one and one half hour fire doors. The Therapy Hall and Service Hall sets of fire doors failing to latch was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the 12:45 p.m. exit conference on 07/19/11. 3.1-19(b)		other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?The maintenance man has checked all fire doors on all other areas and the fire doors close properly.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?Doors will be tested monthly when the fire alarm is activated and inspected for properl operation, which includes closing and latching.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?QA&A will monitor on a monthly basis. Maintenance will audit closing of the fire doors monthly.QA will review audit monthly for 6 months and members will determine if to continue.Mainttence to monitor.Deadline: 8/18/11	
K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5			

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	Based on observation and interview, the facility failed to ensure 1 of 78 rooms was provided with complete sprinkler coverage. This deficient practice could affect any resident using the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 07/19/11 during a tour of the kitchen from 11:15 a.m. to 11:40 a.m. with the maintenance supervisor, the twenty foot dead end corridor near the food storage room pantry had one standard pendant sprinkler located twenty two feet from the end of the twenty foot dead end corridor with no other sprinkler coverage visible. Based on an interview with the maintenance supervisor on 07/19/11 at 11:30 a.m., the kitchen pantry corridor was identified as needing additional sprinkler coverage by the sprinkler inspection contractor two years ago, but it was not corrected. The lack of adequate sprinkler coverage in the twenty foot dead end corridor in the kitchen was acknowledged by the administrator at the 12:45 p.m. exit conference on 07/19/11. 3.1-19(b)	K0056	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Sprinkler head was ordered on 7/19/11 from the sprinker system contractor PIPE. The sprinkler head is expected to be installed by PIPE no later that 8/18/11.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?77 of 78 rooms have sprinklers as indicated on the 2567.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?Maintenance inspected the facility sprinkler heads(365) from 7/19/11-7/20/11 and found no other voids in coverage. Quarterly inspection will be done by PIPE. They will check for location and functionality.	08/18/2011